

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/20/2011
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF ANDERSON		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 CROWNPOINTE CIR ANDERSON, IN 46012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the post survey revisit to the Investigation of Complaint IN00095111 investigated on 9/13/11.</p> <p>Survey date: October 20, 2011</p> <p>Facility number: 012129 Provider number: 012129 AIM number: N/A</p> <p>Surveyor: Jeri Curtis, RN</p> <p>Census bed type: Residential: 40 Total: 40</p> <p>Census payor type: Medicaid: 8 Other: 32 Total: 40</p> <p>Sample: 2</p> <p>Crownpointe of Anderson was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00095111.</p> <p>Quality review completed 10/23/11 Cathy Emswiller RN</p>	{R 000}		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

RVLV12

If continuation sheet 1 of 1